DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185314	A. BUILDING _____ B. WING _____	C 08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	116 PIONEER TRACE FLEMINGSBURG, KY 41041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Recertification and Abbreviated Survey, for ARO KY # 00014884 was conducted 08/24/10 through 08/26/10. A Life Safety Code Survey was conducted on 08/24/10. Deficiencies were cited with the highest scope and severity of a "F". ARO number KY00014884 was substantiated with deficiencies cited.	F 000	F000 This plan of correction is not meant to establish any standard of care, contract obligation or position and Pioneer Trace Nursing Home reserves the right to raise all possible contentions and defenses in any type of civil or criminal claims, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver to any potentially applicable peer review, quality assurance or self critical examination privileges which Pioneer Trace Nursing Home does not waive and reserves the right to assert any administrative, civil, or criminal action or proceeding. Pioneer Trace Nursing Home offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

RECEIVED
SEP 17 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to protect and promote the rights of resident(s) in one (1) of fifteen (15) residents, Resident #15. On 03/18/10, Resident # 15 was discharged from the facility and admitted to the hospital. This resident was readmitted to the facility on 03/29/10 into a different room. However, the Power of Attorney was not notified of the room change. The findings include: Review of the facility's Resident Rights Policy revealed: Under the section titled Notice of Rights and Services, #10 ii ; " the facility will promptly notify the residents' legal representative or interested family member when there is - A. A change in room or roommate assignment." Review of Resident #15 clinical record revealed the resident was admitted with diagnoses which included Hypertension, Diabetes Mellitus and Dementia. On 08/24/10 at 4:00 PM, interview with the resident's Daughter revealed she was not aware of Resident #15 being readmitted to a different room post hospital discharge (for previously stated date). Further interview revealed the Daughter came to the facility to see the resident shortly after being readmitted and did not find the resident in his/her usual room. When she did locate him/her, the resident was upset and	F 157	F 157 Resident #15 was readmitted to the facility to a different room due to his increasing behaviors possibly affecting others. When the resident POA visited the facility she was informed by staff the location of Resident # 15 's new room. Resident # 15 no longer resides in the facility. The Social Services Director reviewed all current residents' charts to ensure that the legal representatives or interested family members were notified of room changes on 09/11/10. No residents were found to be affected by this deficient practice. The Unit Coordinator and DON reviewed all current residents' charts to ensure that the legal representatives or interested family members were notified of any accidents, significant changes, the need to alter treatment, and transfers or discharges on 09/15/10 and 09/16/10. No residents were found to be affected by this deficient practice. The Social Services Director and/or Charge Nurse will notify the legal representative or interested family member of any room changes that occur and SSD and Nurses were in-serviced by the Administrator on 09/13/10 and 9/14/10. The Social	

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F 157	Continued From page 2 stated: "This is not my room! My stuff has been moved around!" On 08/25/10 at 11:30 AM, interview with the facility Administrator revealed she did not know the usual procedure for notifying the family or responsible party regarding a bed change. Further interview revealed the Social Services Director was responsible for this category of resident care. On 08/25/10 at 2:35 PM, interview with the Social Services Director revealed she notified a resident's responsible party of bed changes as a courtesy to the responsible parties. Further interview revealed it was the responsibility of the nurse on that resident's unit to notify responsible parties of a resident room change when they are readmitted from the hospital or any other facility. On 08/26/10 at 12:55 PM, interview with LPN #3, who was Resident #15's admitting nurse on 03/29/10, revealed she spoke with his/her Daughter on the phone regarding the readmission on that date but could not recall if she specifically told the Daughter the resident was readmitted to a different room. Review of the Nurses' Notes revealed no documentation regarding family notification of room assignment change, related to Resident #15.	F 157	Services Director implemented a new form to be mailed to the legal representative or interested family member to notify them when a room change occurs (Attachment A). The Social Services Director sent a request to verify current address and phone number of the residents' legal representative or interested family member on 09/16/10. Facility Administration reviewed current policy and procedure for notification of accidents, significant changes, the need to alter treatment, and transfers and discharges on 09/15/10 and the Unit Coordinators and DON in-serviced all Nurses on the Notification of Change in Residents Condition policy on 09/16/10 and 09/17/10. The Unit Coordinators and Medical Records will monitor the Charge Nurses and SSD daily (Sunday-Saturday) to ensure prompt notification of the legal representative or interested family member of any room changes that occur. The Unit Coordinators will monitor the Charge nurses daily (Sunday – Saturday) to ensure prompt notification of the legal representative or interested family member of any accidents, significant changes, need to alter treatment and transfer and discharge. The Unit Coordinators will maintain a daily logbook of their daily monitoring of notification of room	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

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F 282	Continued From page 3 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure care was provided in accordance with residents' Comprehensive Plan of Care for three (3) out of fifteen (15) sampled residents (Resident #10, #11, and #12). The findings include: 1. Review of Resident #10's clinical record revealed diagnoses which included Blind in right eye, Dementia, Hallucinations, Coronary Artery Disease (CAD) and Hypertension. Review of the Minimum Data Set (MDS) dated 05/28/2010 revealed the facility assessed Resident #10 as being moderately impaired related to cognition, poor decisions making skills and as needing cueing and supervision. Review of Resident #10's Comprehensive Plan of Care, dated 08/25/2010, revealed the facility had identified the resident as being at risk for falls. The Plan of Care included an intervention for the use of a pressure alarm while up in a wheelchair, as well as a pressure alarm to bed. Observation of Resident #10, on 08/24/2010 at 5:55 PM, in the dining room revealed the resident failed to have a pressure alarm in place, while up in a wheelchair. Interview with Licensed Practical Nurse (LPN) #1, on 08/26/2010 at 2:38 PM revealed she did not	F 282	changes, accidents, the need to alter treatment, significant changes, and transfers and discharges. The Administrator will audit the SSD's implementation of the new notification of room change form by comparing room changes with the notification log weekly. The Unit Coordinators will report all findings to the DON Monday-Friday in the morning QA meeting and monthly to the Quality Assurance Committee. The Unit Coordinators and Medical Records will report all findings to the Administrator immediately and to the Quality Assurance Committee monthly (comprised of the Administrator, DON, Unit Coordinators, Medical Director, MDS Coordinator, SSD, Consulting Pharmacist, and Owners) monthly. The Administrator and DON will report all findings to the Quality Assurance Committee monthly. The Quality Assurance Committee will review the results reported and will track and trend the results to determine if changes are needed or further staff education is warranted.	09/18/10

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F 282	Continued From page 4 have any idea why alarm was not on Resident #10's wheelchair. LPN #1 revealed all staff had been given report related to the use of alarms , that they soul be in place. 2. Review of the clinical record revealed Resident #11 had diagnoses which included Dementia, Parkinson's Disease, Osteoarthritis and Macular Degeneration. Review of the MDS dated 07/12/10 revealed the facility assessed Resident #11 as having poor decision making skills and supervision was needed. Review of Resident #11's Comprehensive Plan of Care, dated 05/13/10, revealed the the facility had identified the resident as being at risk for falls. An intervention of the Plan of Care included the use of a bathroom door alarm In order to alert staff to Resident #11's attempts to toilet without asking for assistance. Observation on 08/26/10 at 2:55 PM of Resident #11's bathroom revealed when the bathroom door was opened no alarms sounded. Interview with LPN #3 on 08/26/10 at 3:05 PM revealed the alarm was turned off. LPN #3 indicated the alarm should always be turned on due to Resident #11's risk for falls. The nurse stated the alarm alerts staff the Resident is attempting to toilet alone. Further interview revealed LPN #3 was unaware of how long the bathroom door alarm has been turned off and indicated the alarm was important because the Resident will attempt to toilet alone. Record review revealed the bathroom alarm had	F 282	F 282 Resident # 10's pressure alarm was immediately placed in wheelchair. Resident #11's bathroom door alarm was immediately turned on. Resident # 12's Dycem was immediately placed in her bedside chair. The Unit Coordinators reviewed all residents care plans to ensure care plans were being followed on 08/31/10, 09/01/10, 09/02/10. No residents were found to be affected by this deficient practice. The Unit Coordinators will be responsible for conducting daily (Sunday-Saturday) rounds to ensure staff implementation of the residents' plan of care. All nursing staff was in-serviced by the Administrator and Unit Coordinator on 09/13/10 and 09/14/10 on consistently following a resident's plan of care. The Unit Coordinators will report all findings to the DON Monday-Friday in the morning QA meeting and monthly to the Quality Assurance Committee. The Quality Assurance Committee will review the results reported and will track and trend the results to determine if changes are needed or further staff education is warranted.	09/15/10

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F 282	Continued From page 5 been added to the Comprehensive Care Plan on 05/13/10 to alert staff to Resident #11 attempting to toilet alone. 3. Review of Resident #12's clinical record revealed diagnoses which included Cerebrovascular Accident, Dementia, Osteoarthritis, and history of Left Hip Fracture. Review of the MDS dated 08/11/10 revealed the facility assessed the resident as having poor decision making skills and needing supervision. Review of Resident #12's the Comprehensive Care Plan, dated 08/11/10, revealed the facility had identified the resident as being at risk for fall. An intervention of the Plan of Care included the use of Dycem to his/her bedside chair, which was added to the plan on 05/02/10. Observation on 08/26/10 at 3:25 PM revealed Resident #12 failed to have the Dycem on the bedside chair. Interview with LPN #3 on 08/26/10 at 3:25 PM revealed Resident #12 was to have Dycem to bedside chair to keep him/her from slipping out of the chair.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 Resident # 10's pressure alarm was immediately placed in wheelchair. Resident #11's bathroom door alarm was immediately turned on. Resident # 12's Dycem was immediately placed in her bedside chair. The Unit Coordinators reviewed all residents care plans to ensure care plans were being followed on 08/31/10, 09/01/10, and 09/02/10.	

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the resident environment remains as free of accident hazards as possible; and each resident received assistive devices to prevent accidents for three (3) out of fifteen (15) sampled residents (Resident: #10, #11, and #12). The findings include: 1. Review of the clinical record revealed Resident#10 diagnoses which included Blindness in Right Eye, Dementia, Hallucinations and Coronary Artery Disease (CAD) and Hypertension. Review of the Minimum Data Set (MDS) dated 05/28/2010 revealed the facility assessed the resident to be modertely impaired related to cognition, with poor decision making skills, and needing supervision. The Comprehensive Care Plan, dated 08/25/2010, was reviewed and revealed Resident #10 was to have apressure alarm to his/her wheelchair when up and while in bed. The faility had idetnified Resident #10 was to be at risk for falls. However, Resident #10 was observed, on 08/24/10 at 5:55 PM, to not have the pressure alarm in place on his/her wheelchir. Interview with Licensed Practical Nurse (LPN) #1, on 08/26/2010 at 2:38 PM revealed she was unaware why the resident's alarm was not in place. LPN #1 stated that all staff had been given report for all alarms, and were expected to ensure	F 323	The Unit Coordinators checked to ensure all devices and interventions were implemented and working properly on 08/26/10. No other residents were found to be affected by this deficient practice. An environmental tour of the facility was conducted by the Unit Coordinator and the Maintenance Director on 08/31/10. No areas of concern were identified. The Medication Aides will be responsible for conducting a daily (Sunday-Saturday) check of all physician ordered fall prevention measures to ensure they are in place and working properly. The Medication Aides will be responsible for completing a daily log book of their checks. Nursing staff were in-serviced on 09/13/10 and 09/14/10 on conducting the checks of ordered fall prevention measures by the Administrator and Unit Coordinator. The Unit Coordinators will be responsible for checking the Medication Aide log book to ensure implementation of daily checks. The Unit Coordinators will report all findings to the DON Monday-Friday in the morning QA meeting and monthly to the Quality Assurance Committee. The Maintenance Director will conduct a weekly environmental tour of the facility	

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F 323	Continued From page 7 they were in place. Interview with Director of Nursing (DON) on 08/26/2010 at 2:43 PM revealed that on 08/24/2010 (diuring the survey) all Unit Coordinators had Inserviced staff on restraint vs alarms usage and a memo was placed at each nursing station. 2. Review of the clinical record revealed Resident #11 diagnoses which included Dementia, Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Osteoarthritis and Macular Degeneration. Review of the MDS dated 07/12/10 revealed the facility assessed Resident #11 as having poor decision making skills and supervision was needed. Record review revealed the use of a bathroom door alarm was added to the Comprehensive Plan of Care on 05/13/10 to alert staff to Resident #11's attempts to toilet without asking for assistance. This resident was identified by the facility as being at risk for falls. However, obervation on 08/26/10 at 2:55 PM revealed Resident #11's bathroom door was opened and no alarms sounded. LPN #3 was interviewed on 08/26/10 at 2:38 PM and stated the alarm was turned off. LPN #3 indicated the alarm should always be turned on because Resident #11 was a fall risk so the alarm alerts staff the resident was attempting to toilet alone. LPN #3 was unaware of how long the bathroom alarm had been turned off and indicates this was important because the resident woul attempt to toilet alone. 3. Review of the clinical record revealed	F 323	to ensure the facility remains as free of accident hazards as possible. The Maintenance Director will report all findings to the Administrator Monday-Friday in the morning QA meeting and monthly to the Quality Assurance Committee and Safety Committee. The Quality Assurance Committee and Safety Committee will review the results reported and will track and trend the results to determine if changes are needed or further staff education is warranted. 09/15/10	

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F 323	Continued From page 8 Resident #12 diagnoses included Cerebrovascular Accident, Dementia, Osteoarthritis, and history of Left Hip Fracture. Review of the MDS dated 08/11/10 revealed the facility had assessed the resident to have poor decision making skills and needing supervision. The Comprehensive Care Plan dated 08/11/10 revealed an intervetion related to the use of Dycem to his/her bedside chair, and was identifed to be at risk for falls. However, observation on 08/26/10 at 3:25 PM revealed Resident #12 Dycem was not placed in the bedside chair. Interview with LPN #3 on 08/26/10 at 3:25 PM revealed Resident #12 was to have Dycem to bedside chair to keep her from slipping out of the chair. She further explained to the CNAs who were using a lift to raise the Resident from the chair the Dycem was to go on top of the absorbant pad in the bedside chair. Record review revealed the Dycem had been added to the Comprehensive Care Plan on 05/02/10 related to Resident #12 being considered at risk for falls.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 The Maintenance Director immediately removed the ice on the freezer door. The Dietary Manager immediately removed the turkeys from their location and placed them on the bottom shelf of the refrigerator. The Dietary Manager immediately removed the plastic storage boxes and placed them at least 18 inches from the ceiling. The Dietary Manager	

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F 371	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions. The findings include: 1. Observation on 08/24/10 at 11:45 AM revealed a large amount of ice build up was noted on the inside of the freezer door. The ice was observed to be approximately a half and inch thick. Interview with the Dietary Manager on 08/24/10 at 11:50 AM revealed maintenance scrapes the ice off of the door when the staff notify him of the need. She further indicated a contractor was supposed to be coming to fix the door seal and maintenance was responsible for calling the contractor. She stated the door had been in this condition for a couple of months. Interview with the Maintenance Supervisor on 08/24/10 at 5:25 PM revealed the facility had ordered and received the new gasket, however the contractor had not been called to the facility at the present time. He further indicated the ice was chipped off of the door approximately once each week and the gasket/seal that was currently on the door had been replaced in April. He states that every couple of months the gasket must be replaced and it has been this way for a long time. 2. Observation on 08/24/10 at 11:49 AM revealed two (2) frozen turkeys sitting in a metal baking pan in the refrigerator, thawing on top of a plastic	F 371	and Maintenance Director conducted an inspection of the refrigerator; freezer and storage area to ensure there were no other areas of concern on 08/24/10. No additional areas of concern were identified. The Dietary Manager conducted a sanitation audit of the entire kitchen on 08/27/10 and no areas of concern were identified. Fizers Refrigeration will install the new gasket and adjust the inside striker plate on the freezer on 09/13/10. In-service held for all dietary staff on 09/03/10 and 09/09/10 on proper refrigerated storage/thawing methods and on dry storage by the Dietician and Dietary Manager. The Dietary Staff were in-serviced on 09/17/10 by the Dietician on maintaining proper sanitary conditions throughout the kitchen. The Maintenance Director will conduct a weekly inspection of the freezer to ensure there is no ice build up. The Dietary Manager will conduct a weekly inspection of the refrigerator and dry storage area to ensure all items are stored properly. The Dietary Manager will complete a weekly sanitation audit and the Dietician will complete a monthly sanitation audit of the kitchen. The Dietary Manager and Dietitian will report all findings to the Administrator weekly in the morning QA meeting and	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185314	A. BUILDING _____ B. WING _____	C 08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	116 PIONEER TRACE FLEMINGSBURG, KY 41041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 container in which onions were stored uncovered. Interview with the Dietary Manager on on 08/25/10 at 11:45 AM revealed the turkeys had been removed from over top of the onions and placed on the bottom rack of the refrigerator to thaw. She further indicated they were fully cooked turkeys but still should not have been placed on top of the onions and were moved to the lower rack of the refrigerator to thaw. 3. Observation of the dry food storage area on 08/24/10 at 11:25 AM revealed plastic storage boxes containing items such as artifical sweeteners were noted to be stored nine (9) and three (3) quarters of an inch from the ceiling. This was noted to exist for an approximate five (5) feet length along the wall in the dry storage area. Interview with the Dietary Manager on 08/26/10 at 4:30 PM revealed the stock in dry storage should not be stacked any closer to the ceiling than eighteen inches (18) from the ceiling due to fire hazard. She further indicated the reason stock was stacked too high was because the kitchen staff did not have enough room for the stock required to operate.	F 371	monthly to the Quality Assurance Committee. The Maintenance Director and Dietary Manager will report all findings to the Administrator weekly in the morning QA meeting and monthly to the Quality Assurance Committee. The Quality Assurance Committee will review the results reported and will track and trend the results to determine if changes are needed or further staff education is warranted.	09/18/10

Pioneer Trace
Nursing and Rehabilitation
101 Pioneer Trace
Flemingsburg, KY 41041
(606)845-2131

NOTIFICATION OF ROOM CHANGE

This is to inform you that _____ was moved to room

_____ on _____. If you have any questions, please contact the

facility at (606)845-2131.

Thank You,

_____

Facility Representative

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185314	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/24/2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/24/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F ".	K 000	K000 This plan of correction is not meant to establish any standard of care, contract obligation or position and Pioneer Trace Nursing Home reserves the right to raise all possible contentions and defenses in	
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors in smoke barriers were, according to NFPA codes. The Findings Include: Observation on 08/24/2010 at 12:20 PM, revealed a total of five (5) smoke barrier access doors located in the attic had make shift doors in the smoke barriers. These doors must be approved doors designed for this use. Interview on 08/24/2010 at 12:20 PM, with the Maintenance Director, revealed he was unaware	K 027	any type of civil or criminal claims, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver to any potentially applicable peer review, quality assurance or self critical examination privileges which Pioneer Trace Nursing Home does not waive and reserves the right to assert any administrative, civil, or criminal action or proceeding. Pioneer Trace Nursing Home offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

RECEIVED
SEP 15 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Hutson — TITLE: Administrator — (X6) DATE: 9/15/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	186314	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	115 PIONEER TRACE FLEMINGSBURG, KY 41041

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K 027	Continued From page 1 that access doors in the smoke barrier had to be of an approved design. Reference: NFPA 101 (2000 Edition). 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable	K 027	K027 The Facility purchased five (5) smoke barrier access doors that meet and exceed the requirements of NFPA 101. The new smoke barrier access doors were installed on 09/13/10 and 09/14/10. The Maintenance Director will perform a weekly walk-thru inspection of the attic to ensure the new smoke barrier access doors remain in proper working order. The Maintenance Director will report all findings immediately to the Administrator and to the Quality Assurance Committee and Safety Committee monthly. The Quality Assurance Committee and Safety Committee will review the results reported and will determine if any changes are warranted.	09/15/10

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K 027	Continued From page 2 of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 027		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained, according to NFPA standards. The findings include: Observation on 08/24/2010 at 12:40 PM, revealed two (2) sprinkler heads in the kitchen area had a buildup of lint and grease. Further observation revealed one (1) sprinkler head in the oxygen storage room was corroded. The observations were confirmed with the Maintenance Director, at the time of the observation. Sprinkler heads must be kept free of lint, grease and corrosion to ensure the sprinkler heads function in the event of a fire.	K 062	K 062 The two sprinkler heads in the kitchen were immediately cleaned. Simplex Grinnell replaced the sprinkler head in the oxygen storage room on 09/14/10. The Dietary Manager added routine weekly cleaning of the sprinkler heads in the kitchen to the current cleaning schedule each Tuesday. Dietary cleaning staff was in-serviced by the Dietary Manager and Maintenance Director on 09/14/10 on proper cleaning of sprinkler heads. The Maintenance Director will perform a weekly inspection of all facility sprinkler heads to ensure they are in proper working order.	

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K 062	Continued From page 3 Interview on 08/24/2010 at 12:40 PM, with the Maintenance Director, revealed he was unaware of the deficient sprinkler heads. Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	The Maintenance Director will report all findings immediately to the Administrator and to the Quality Assurance Committee and Safety Committee monthly. The Quality Assurance Committee and Safety Committee will review the results reported and will determine if any changes are warranted.	09/15/10
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors were maintained free from obstructions to full instant use, in the case of fire or other emergency, according to NFPA standards. The findings include: Observation on 08/24/2010 at 12:37 PM, revealed in the A corridor there were three (3) medicine carts and two (2) clean linen carts found	K 072	K 072 The medicine carts and clean linen carts were immediately removed from A corridor and B corridor while not in use. The Nursing staff was in-serviced on 09/14/10 on proper storage of the medicine and linen carts while not in use by the Administrator. The Unit Coordinators will conduct daily rounds to monitor proper storage of the carts while not in use. The Unit Coordinators will report all findings to the DON Monday-Friday in the morning QA meeting and monthly to the Quality Assurance Committee and the Safety Committee. The Quality Assurance Committee and the Safety Committee will review the results reported and will track and trend the results to determine if changes are needed or further staff education is warranted.	09/15/10

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K 072	Continued From page 4 unattended and not in use. Further observation on the B Corridor revealed there were three (3) medicine carts and two (2) clean linen carts found to be unattended and not in use. These items also blocked the handrails for residents that may have needed to use them. The observations were confirmed with the Director of Maintenance, at the time of the observation. Interview on 08/24/2010 at 12:37 PM, with the Director of Maintenance, revealed the medicine carts and clean linen carts were routinely left in the corridors.	K 072		
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure combustible decorations were not in use, according to NFPA standards. The findings include: Observation on 08/24/2010 at 12:30 PM, revealed combustible wreaths were found on resident's room doors, the room included rooms numbers 12, 34, and 29. The observation was confirmed with the Maintenance Director, at the time of the observation. Interview on 08/24/2010 at 12:30 PM, with the Maintenance Director, revealed the facility does not treat decorations with any kind of fire retardant.	K 073	K 073 The wreaths were removed immediately on room numbers 12, 34, and 29. The Maintenance Director conducted a walk-thru inspection of the facility and found no other decorations of concern on 08/24/10. The Social Services Director will send a letter to all current residents' families informing them that all new decorations brought into the facility must be inspected by the Maintenance Director prior to placement in a resident room. The Activities Director will conduct an inspection of the facility weekly to ensure no items are brought into the facility of concern.	

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K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure combustible materials were not stored within five (5) feet of oxygen cylinders, according to NFPA standards. The findings include: Observation on 08/24/2010 at 1:04 PM, revealed combustible materials, which included toilet paper, cardboard boxes and cleaning supplies, were stored within five (5) feet of oxygen cylinders. The observation was confirmed with the Maintenance Director, at the time of the observation. Interview on 08/24/2010 at 1:04 PM, with the Maintenance Director, revealed he was unaware that combustibles should not be stored within five (5) feet of the oxygen cylinders.	K 076	The Activities Director will report all findings to the Maintenance Director immediately. Any item of concern will be removed from the facility or treated with fire retardant. The Maintenance Director will report the findings to the Administrator immediately and to the Quality Assurance Committee and Safety Committee monthly. The Quality Assurance Committee and Safety Committee will review the results reported and will determine if any changes are warranted.	09/15/10

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K 076	Continued From page 6 Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076	K 076 The combustible materials were immediately removed from the oxygen storage room. There are no other oxygen storage areas in the facility so no other areas of concern were identified. The combustible materials are now stored in a different location. The Maintenance Director will perform a weekly inspection to ensure no combustible items are stored in the oxygen storage room. The Maintenance Director will report the findings to the Administrator immediately and to the Quality Assurance Committee and Safety Committee monthly. The Quality Assurance Committee and Safety Committee will review the results reported and will determine if any changes are warranted.	08/25/10